1

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12085

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 41 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 16 Queen City Pavement, Cumberland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 16 Queen City Pavement
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold; Middle: ; Last: Ashworth

4. DATE OF DEATH: Month: September; Day: 2; Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 27, 1901

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months: ; Days:
   IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Celanese Employee

10b. KIND OF BUSINESS OR INDUSTRY: Celanese

11. BIRTHPLACE (State or foreign country): Bolton, Lancashire, England

12. CITIZEN OF WHAT COUNTRY? England

13. FATHER'S NAME: Thomas Ashworth

14. MOTHER'S MAIDEN NAME: Pamela Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-07-1536

17. INFORMANT: Mrs. Betty Fey
   Address: Baltimore Pike, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
   DUE TO
   (b): Coronary Sclerosis — ---
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: Sept. 2, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-4-66

23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Maryland

24. FUNERAL DIRECTOR: Dale L. Merritt
   ADDRESS: 404 Decatur St. Cumb., Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12090

CERTIFICATE OF DEATH

12086

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 24 WEBER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle F. Last ASKEY

4. DATE OF DEATH: Month SEPTEMBER Day 13 Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-1-1900

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Kennedy Co

11. BIRTHPLACE (County & State, or foreign country): W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY ASKEY (D)

14. MOTHER'S MAIDEN NAME: ABBIE (D) Hilshire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: PT'S CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Shutdown due to Shock — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Myocardial infarction, portion, acute — 3 days
DUE TO
(c): Coronary Thrombosis — Arteriosclerotic heart disease — 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/10, 1966 to 9/13, 1966, that (I) (we) last saw the deceased alive on 9/13 1966, and that death occurred at 5:40 P.M. from causes and on the date stated above.

22a. SIGNATURE: S Weisman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/13/66

22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN, M.D.

22d. ADDRESS: 59 GREENE ST. CUMBERLAND, MARYLAND.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/16/66

23c. NAME OF CEMETERY OR CREMATORY: Zion Memo. Cem.

23d. LOCATION (City or Town) (County) (State): Cumberland Md.

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: SEP 16 1966

25b. REGISTRAR'S SIGNATURE: Florence Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. Page 1 any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12091 — 12087

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hazel — Middle: Elizabeth — Last: Athey

4. DATE OF DEATH: Month: September — Day: 10 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 25, 1893

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Allegany Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry Snyder

14. MOTHER'S MAIDEN NAME: Mrs. Emma Kirtley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-34-1966

17. INFORMANT — Address: Mrs. Francis Hess, Route 1, Oldtown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, metastatic secondary — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): to below Carcinoma — 2 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 21, 19 66, to 9-10, 19 66, that (I) (we) last saw the deceased alive on 8-8 19 66 and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Carlton Brinsfield — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): CARLTON BRINSFIELD MD

22d. ADDRESS: 401 DECATUR ST

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 13, 1966

23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Lutheran Cem

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer 230 Balto Ave., Cumberland, Md
John J. Hafer

25a. REC'D BY REGISTRAR — DATE: SEP 14 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12092

CERTIFICATE OF DEATH

12088

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 23HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: W.VA. — b. COUNTY: HANPSHIRE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SPRINGFIELD
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MR. Middle CHARLES L. Last BAZZLE
4. DATE OF DEATH: Month SEPT. Day 24 Year 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/1/94
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MICHAEL BAZZLE
14. MOTHER'S MAIDEN NAME: AMANDA BAKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH
260 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Diabetic Acidosis
DUE TO
(c): Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/23, 19 66 to 9/24, 19 66, that (I) (we) last saw the deceased alive on 9/24 19 66 and that death occurred at 1.00 PM, from causes and on the date stated above.

22a. SIGNATURE: Leo A Ley Jr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/26/66
22c. PHYSICIAN'S NAME (Type): DR. LEO LEY
22d. ADDRESS: 456 N. CENTRE ST. CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-27-66
23c. NAME OF CEMETERY OR CREMATORY: Springfield Hill
23d. LOCATION (City or Town) (County) (State): Springfield Hampshire, W, Va.
24. FUNERAL DIRECTOR: Earl D Slaffer — ADDRESS: Romney, W, Va.
25a. REC'D BY REGISTRAR DATE: SEP 30 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12093

CERTIFICATE OF DEATH

13466

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Miners Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Grantsville (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Savilla Middle Edith Lost Beeman

4. DATE OF DEATH: Month Sept. Day 27, Year 19 66

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/10/1910
9. AGE (In years lost birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Somerset Co., Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dan Stevanus
14. MOTHER'S MAIDEN NAME: Nora Kendall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: ---
17. INFORMANT Address: Mr. Henry Beeman, Grantsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Primary ovarian carcinoma — 18 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1750

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-22-, 1966, to 9-26-, 1966, that (I) (we) last saw the deceased alive on 9-25-19 66, and that death occurred at 4:35 AM, from causes and on the date stated above.

22a. SIGNATURE: G. Paige Strong — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/13/66
22c. PHYSICIAN'S NAME (Type): A. Paige Strong
22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/29/66
23c. NAME OF CEMETERY OR CREMATORY: St. Paul, Pa. Cem.
23d. LOCATION (City or Town) (County) (State): R.D. Meyersdale Somerset Pa.

24. FUNERAL DIRECTOR: Don Newman
ADDRESS: Grantsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12094

CERTIFICATE OF DEATH

12089

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 52 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 574 Winifred Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: M. — Last: Preighner

4 DATE OF DEATH: Month: Sept. — Day: 20, — Year: 19 66

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 7, 1913

9 AGE (In years last birthday): 52 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b KIND OF BUSINESS OR INDUSTRY: Railroad

11 BIRTHPLACE (County & State, or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Roy M. Breighner

14 MOTHER'S MAIDEN NAME: Bertha Dove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Pr II

16. SOCIAL SECURITY NO: 214-05-8613

17 INFORMANT — Address: Mrs. Eleanor Preighner Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): Arteriosclerotic Cardiovascular Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 16, 1952, to June 23, 19 66 that (I) (we) last saw the deceased alive on Sept. 15 19 66, and that death occurred at 3 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 20, 1966

22c PHYSICIAN'S NAME (Type): Dr. G. Overton Himmelwright

22d ADDRESS: 133 Virginia Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 23, 1966

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarelli — ADDRESS: Cumberland, Md.

25a REC'D BY REGISTRAR DATE: SEP 26 1966

25b REGISTRAR'S SIGNATURE: Marie Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12090

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND / Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 111 N. Walnut Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lily; Middle: Mae; Last: Brown

4. DATE OF DEATH: Month: September; Day: 29; Year: 1966

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 27, 1886

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Meigs

14. MOTHER'S MAIDEN NAME: Elizabeth Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: 220-10-2598D

17. INFORMANT: James L. Brown, 111 N. Walnut Place, Cumberland
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Corona ry Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 Minutes
DUE TO (b): Coronary Sclerosis — ----
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour ____ a.m. p m; Month, Day, Year 19____

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic MD

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: September 29, 1966

Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: October 3, 1966

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
ADDRESS

22d. LOCATION (City, town, or country) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR: John J. Hafer
John J. Hafer, 230 Balto Ave., Cumberland, Md

24a. REC'D BY REGISTRAR DATE: OCT 5 1966

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12091

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 Hrs. 35 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Tennessee — b. COUNTY: Hawkins
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Surgoinsville
d. STREET ADDRESS: Rt. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: James — Middle: Sherrell — Last: Burke

4 DATE OF DEATH: Month: Sept. — Day: 10, — Year: 19 66

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 10, 1945

9 AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lee Burke

14. MOTHER'S MAIDEN NAME: Virginia Haygood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — At Present

16. SOCIAL SECURITY NO: 413-68-1760

17. INFORMANT — Address: Hugh E. Housewright, Jr. Surgoinsville Tenn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial Hemorrhage
DUE TO (b): Skull Fracture; Transection of second cervical vertebrae
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: About 4 Hours

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
Automobile collision

20c. TIME OF INJURY Month, Day, Year: Hour 6:00 p.m. Sept. 10 19 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route # 28, Near Wiley Ford, Mineral, WVA

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: September 10, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 16, 1966

23c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

23d. LOCATION (City or Town) (County) (State): Surgoinsville, Tenn.

24. FUNERAL DIRECTOR — ADDRESS: Philip B. Wendt 121 Memorial Ave. Cumb. Md.

25a. REC'D BY REGISTRAR — DATE: SEP 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12097

CERTIFICATE OF DEATH

12092

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 48 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: PENNSYLVANIA b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYNDMAN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle M. Last BURKETT

4. DATE OF DEATH: Month SEPTEMBER Day 22 Year 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-31-87

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RAILROAD Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Bedford Co. Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LEVIAH BURKETT

14. MOTHER'S MAIDEN NAME: CATHERINE LOWERY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 705-09-5917

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Metastasis
DUE TO (b): Colon Carcinoma Ca Pontis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-25-66, 19 1:45 A.M. 9-22, 19 66, that (I) (we) last saw the deceased alive on 9-22 19 66 and that death occurred at . M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): DR. J. VALDES

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Sept. 25 1966

23c. NAME OF CEMETERY OR CREMATORY: Palo Alto Cemetery

23d. LOCATION (City or Town) (County) (State): Hyndman Bedford Co. Pa

24. FUNERAL DIRECTOR: Harvey H. Feagley ADDRESS: Hyndman, Pa

25a. REC'D BY REGISTRAR DATE: SEP 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12093

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 65 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 38 VIRGINIA AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN — Middle M. — Last CAGE

4 DATE OF DEATH: Month SEPTEMBER — Day 15 — Year 1966

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 9-11-82

9 AGE (In years last birthday): 84 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11 BIRTHPLACE (State or foreign country): MARTINSBURG, W.VA.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Charles E. Cage

14 MOTHER'S MAIDEN NAME: Leah F. Staubs

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes Peace Time

16 SOCIAL SECURITY NO:

17 INFORMANT — Address: PT'S CHART

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Subdural Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
7240
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Contusions of Brain — 4 days
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Fell at Home

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 9:00 p.m. Sept. 11 1966

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) (County) (State): Cumberland, Alleg. Md.

21 I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Benedict Skitarelic M.D — BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: September 15, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Sept. 18, 1966

23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24 FUNERAL DIRECTOR — ADDRESS: James F. Scarnelli, Cumberland, Md.

25a REC'D BY REGISTRAR DATE: SEP 19 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12094

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN To
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D. O. A. Sacred Heart Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rt. # 6 Cumberland,
d. STREET ADDRESS: Rawlings,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Vance — Middle: Louie — Last: Chucci

4. DATE OF DEATH: Month: Sept. — Day: 17, — Year: 1966

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1925

9 AGE (In years last birthday): 41 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b KIND OF BUSINESS OR INDUSTRY: Bakery

11 BIRTHPLACE (State or foreign country): McCoole, Maryland

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry Chucci

14 MOTHER'S MAIDEN NAME: Lula Leatherman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes, (If yes give war or dates of service): W. W. # 2

16 SOCIAL SECURITY NO: 721-16-9533

17 INFORMANT: Mrs. Betty L. Chucci — Address: Rt. # 6 Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS WITH THROMBOSIS — ----
DUE TO (c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED CAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: September 17, 1966

Address (Street, city, town, or coun Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 9/20/66 — 23c NAME OF CEMETERY OR CREMATORY: Abe Cemetery — 23d. LOCATION (City or Town) (County) (State): nr. Ridgeley, Mineral W. Va.

24 FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Maryland

25a REC'D BY REGISTRAR DATE: SEP 22 1966 — 25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12100

CERTIFICATE OF DEATH

12095

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a. STATE: W.VA. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYSER, W.VA.
d STREET ADDRESS: RT. #2, BOX 77
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMETT — Middle L. — Last COX
4. DATE OF DEATH: Month SEPTEMBER — Day 9, — Year 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-8-1966
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours 23 — Min. 20

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country): Cumberland, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: COX, LEONARD LEE
14. MOTHER'S MAIDEN NAME: HAZEL A. KESNER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Prematurity 24 wks — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 6:05 A.M., from causes and on the date stated above.

22a. SIGNATURE: Thomas F. Whitworth M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/12/1966
22c PHYSICIAN'S NAME (Type): DR. F.B. WHITWORTH
22d ADDRESS: 305 WASHINGTON ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 10, 1966
23c. NAME OF CEMETERY OR CREMATORY: Ft Ashby Cemetery
23d. LOCATION (City or Town) (County) (State): Ft Ashby, W. Va.

24 FUNERAL DIRECTOR ADDRESS: Allen M. Rotruck, Keyser W.Va.
25a. REC'D BY REGISTRAR DATE: SEP 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charley Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12102

CERTIFICATE OF DEATH

12096

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 25 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 411 Furnace Street

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 411 Furnace Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jerome — Middle: Patrick — Last: Creegan

4. DATE OF DEATH: Month: September — Day: 22 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 19, 1905

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee-Queen

10b. KIND OF BUSINESS OR INDUSTRY: City Brewing Co.

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Creegan

14. MOTHER'S MAIDEN NAME: Lucy Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-9867

17. INFORMANT: Mrs. Germaine Creegan — Address: 411 Furnace St Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO
(b): Arteriosclero tic Heart Disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4.201
INTERVAL BETWEEN ONSET AND DEATH: Moments

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. , 19 61 to Sept. 22 19 66 that (I) (we) last saw the deceased alive on Aug. 4 19 66 and that death occurred at 9:30 am Sept. 22, 1966 M, from causes and on the date stated above.

22a. SIGNATURE: W C Spiggle — ATTENDING M.D. PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/23/66

22c. PHYSICIAN'S NAME (Type): Wayne C. Spiggle m.d.

22d. ADDRESS: 126 N. Smallwood Street, Cumb.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/66

23c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: Ruth E. Silcox — ADDRESS: Cumberland Maryland 21502

25a. REC'D BY REGISTRAR DATE: SEP 27 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12101

CERTIFICATE OF DEATH

12097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from state; in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT#1, BOX 464
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLEN — Middle NORA — Last CREEK

4. DATE OF DEATH: Month SEPT. — Day 16 — Year 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 5, 1886

9. AGE (In years last b rthday): 80 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY LEE(DECEASED)

14. MOTHER'S MAIDEN NAME: CHARLOTTE RICE (DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 220-10-7761-D

17. INFORMANT: PATI NTS CHART — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR HEMORAHAGE
DUE TO
(b): ESSENTIAL HYPERTENSION
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from 9-2, 1966, to 9-16, 1966, that (I) (~~we~~) last saw the deceased alive on 9-16 19 66, and that death occurred at 4P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-17-66

22c. PHYSICIAN'S NAME (Type): DR. M. GLICK AND DR. W. SPIGGLE

22d. ADDRESS: N. SMALLWOOD ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/18/66

23c. NAME OF CEMETERY OR CREMATORY: Centerville Fshp Cemetery

23d LOCATION (City or Town) (County) (State): Centerville Bedford Penna

24 FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland 21502

25a. REC'D BY REGISTRAR DATE: SEP 19 1966

25b. REGISTRAR'S SIGNATURE: [signature] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12103

CERTIFICATE OF DEATH

12098

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 315 Emily Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stanley — Middle: E. — Last: Davies
4. DATE OF DEATH: Month: 9 — Day: 13 — Year: 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/15/05
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carmen Helper
10b. KIND OF BUSINESS OR INDUSTRY: B & O RR
11. BIRTHPLACE (County & State, or foreign country): Cumberland Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Davies (deceased)
14. MOTHER'S MAIDEN NAME: Alice (deceased) Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 214-05-9373
17. INFORMANT: patient's chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of liver metastatic — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Uremia — 1 week
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January, 1966 to Sept 13, 1966 that (I) (we) last saw the deceased alive on Sept 13 1966, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: B Schindler — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-16-66
22c. PHYSICIAN'S NAME (Type): Dr. B. Schindler
22d. ADDRESS: 43 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 16, 1966
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarnelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: SEP 19 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12104

CERTIFICATE OF DEATH

12099

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 36 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JANE — Middle: H. — Last: DAV$S

4. DATE OF DEATH: Month: SEPTEMBER — Day: 10 — Year: 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITW

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-16-1923

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): GARRETT CO. MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: DANIEL J. HUMMEL

14. MOTHER'S MAIDEN NAME: SARAH E. TURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hodgkins Sarcoma, Generalized — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 19 66 to Sept, 19 66 that (I) (we) last saw the deceased alive on 10 Sept 19 66, and that death occurred at 4:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Fully B Whitworth — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): DR. F. B. WHITWORTH

22d. ADDRESS: 305 WASHINGTON ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/13/66

23c. NAME OF CEMETERY OR CREMATORY: GRANTSVILLE

23d. LOCATION (City or Town) (County) (State): GRANTSVILLE GARRETT Co. MD

24. FUNERAL DIRECTOR — ADDRESS: Don Sherman, Grantsville, Md

25a. REC'D BY REGISTRAR — DATE: SEP 16 1966

25b. REGISTRAR'S SIGNATURE: Charles Savage

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12105

CERTIFICATE OF DEATH

12100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (II) 20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 15 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): rural

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: Rt. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Rose — Middle: Elizabeth — Last: Diehl

4. DATE OF DEATH: Month: Sept. — Day: 3 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 30, 1897

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. Wife
10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): Tucker-W. Va.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James T. Shaffer

14. MOTHER'S MAIDEN NAME: Susan R. Ryan

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO.:

17. INFORMANT: William Diehl — Address: Burlington, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): atherosclerosis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Diabetes mellitus — 20 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Partial Obs

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 1958, to Sept, 1966, that (I) (we) last saw the deceased alive on 9-2-66 19__, and that death occurred at 1 A M, from causes and on the date stated above.

22a. SIGNATURE: William W. Lesh — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-3-66

22c. PHYSICIAN'S NAME (Type): William W. Lesh

22d. ADDRESS: Westernport, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 9/5/66

23c. NAME OF CEMETERY OR CREMATORY: Queens Point

23d. LOCATION (City or Town) (County) (State): Keyser W. Va.

24. FUNERAL DIRECTOR: [illegible] — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE SEP 3 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12106 Items #5,6,7,8 & 9 Film #6381 10/7/66 pc

CERTIFICATE OF DEATH

12101

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grantsville (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DORA — Middle: H. — Last: DURST
4. DATE OF DEATH: Month: 9 — Day: 21 — Year: 1966,
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 4, 1881
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State or foreign country): Avilton, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Sadris McKenzie
14. MOTHER'S MAIDEN NAME: Annie Chaney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-22-1441
17. INFORMANT: Mrs. Carrie Britt — Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arterio Sclerotic Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years
DUE TO (b): Hypertension — 10 years
DUE TO (c): Senility
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
4431

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cellulitis R. lower leg
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2-10, 1960, to 9-21, 1966, that (I) (~~we~~) last saw the deceased alive on 9-20 1966, and that death occurred at 7:50 A.M., from causes and on the date stated above.

22a. SIGNATURE: H.C. Diehl M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-21-66
22c. PHYSICIAN'S NAME (Type): H.C. DIEHL, M.D.
22d. ADDRESS: 39 W. MAIN ST. FROSTBURG, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/24/66
23c. NAME OF CEMETERY OR CREMATORY: New Germany Ref. Cem.
23d. LOCATION (City or Town) (County) (State): Grantsville, Garrett, Md.
24. FUNERAL DIRECTOR: Don Newman
ADDRESS: Grantsville, Md
25a. REC'D BY REGISTRAR DATE: OCT 5 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12107

CERTIFICATE OF DEATH

12102

1 PLACE OF DEATH
a. COUNTY: ALLEGANY CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE
d. STREET ADDRESS: 61 LA VALE COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSILLA MAY — Middle — Last DYCHE
4. DATE OF DEATH: Month SEPT. — Day 2 — Year 19 66

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-30-1889
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): GREAT CACAPON, W. VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM CRAWFORD
14. MOTHER'S MAIDEN NAME: REBECCA A SIPES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: W. H. DYCHE — LA VALE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Coronary Artery Disease
DUE TO
(c): Arteriosclerosis, generalized

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/24, 1966, to 9/2, 1966, that (I) (we) last saw the deceased alive on 9/2 1966, and that death occurred at 6:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: Leo H. Ley Jr. M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/3/66
22c. PHYSICIAN'S NAME (Type): DR. LEO H LEY
22d. ADDRESS: 456 N CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: SEPT. 5, 1966
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK
23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE: SEP 13 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from the state, or in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12108

CERTIFICATE OF DEATH

12103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c LENGTH OF STAY IN 1b: 25 years	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL	d STREET ADDRESS: 448 BALTIMORE AVENUE e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
MARY	VERONICA	FAHEY	9-9		1966

5 SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
FEMALE	WHITE	NEVER MARRIED XX	3-22-93	73-73 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Clerk	Dept. Store	ELK GARDEN MD. W. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Joseph Fahey	Margaret Ellen Carney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT	Address
no			PT'S CHART	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Carcinoma Cecum

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

1536

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/5, 1966 to 9/9, 1966 that (I) (we) last saw the deceased alive on 6/5 1966 and that death occurred at 5:45 P.M. from causes and on the date stated above.

22a SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Leo J. Fahey Jr.		9/9/66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. L. LEY, M.D.	156 N. CENTRE STREET CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 12, 1966	St. Patrick's Cemetery	Cumberland Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	SEP 14 1966	J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12104

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rt. # 4 Cumberland,
d. STREET ADDRESS: Christie Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Patrick — Last: Fairall

4. DATE OF DEATH: Month: Sept. — Day: 18, — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 26, 1919

9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail rtn. employee

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Fairall

14. MOTHER'S MAIDEN NAME: Sarah Schaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes give war or dates of service): W. W. # 2

16. SOCIAL SECURITY NO: 214-07-1974

17. INFORMANT: Address: Mrs. Lillian Fairall Rt. # 4 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Sclerosis — ----
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: September 18, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/21/66
23c. NAME OF CEMETERY OR CREMATORY: Mount Herman Cemetery
23d. LOCATION (City or Town) (County) (State): nr. Cumberland Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 22 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12110

CERTIFICATE OF DEATH

12105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 11/8/1957
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
   d. STREET ADDRESS: Washington Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marie — Middle S. — Last Frankland

4. DATE OF DEATH: Month September — Day 6, — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/17/1873

9. AGE (In years last birthday): 93 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Backnang, Germany

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Christian Stark

14. MOTHER'S MAIDEN NAME: Christina Gensenjager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT P.O.Box 599 Address Cumberland, Md.
    Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① Hypostatic Pneumonia

DUE TO ② Bronchitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO ③ Arteriosclerosis, General

(c) DUE TO ④ Hypertension

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., —, 1966 to Sept. 6, 1966, that (I) (we) last saw the deceased alive on Sept. 5, 1966, and that death occurred at A. M. at 12:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Lee B. Mathews M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 9/6/1966

22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/8/66

23c. NAME OF CEMETERY OR CREMATORY: Philos Cem.

23d. LOCATION (City, town or county) (State): Westernport Md.

24. FUNERAL DIRECTOR: E. J. Bail — ADDRESS: Westernport, md.

25a. REC'D BY REGISTRAR DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12111 — 12106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if competent, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Allegany	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport; c. LENGTH OF STAY IN 1b: 73 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 107 Cromer Street	d. STREET ADDRESS: 107 Cromer Street; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Carrie; Middle: Elizabeth; Last: Gales	4. DATE OF DEATH: Month: September; Day: 29; Year: 19 66
5. SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: March 2, 1893
9. AGE (In years last birthday): 73 yrs.	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Biddle	14. MOTHER'S MAIDEN NAME: Sarah Opal
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no	16. SOCIAL SECURITY NO
17. INFORMANT: Virginia Miller	Address: Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 Hours

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 24, 19 66, to Sept 29, 19 66, that (I) (we) last saw the deceased alive on Sept 28 19 66, and that death occurred at 3 30 A.M. P.M. from causes and on the date stated above.

22a. SIGNATURE: Paul R. Wilson — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 30, 1966

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson, MD

22d. ADDRESS: Piedmont, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 1, 1966	Philos Cemetery	Westernport Allegany, Md.

24. FUNERAL DIRECTOR: C. L. Beal — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 19 66

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12112 — 12107

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 1 week
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Virginia — b COUNTY: Alexandria
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Alexandria
d STREET ADDRESS: 153 Wesmond Drive
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Leona	Ethel	Gormer	Sept.	17	1966

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	White		Jan. 16, 1917	49 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Seamstress	Garment	Cumberland, Md.	USA

13 FATHER'S NAME: Harley Robinette

14 MOTHER'S MAIDEN NAME: (Step) Ida Mae Robinette

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT Address
no		Mr. George Gormer, Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Coronary Sclerosis with Thrombosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)				
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: September 17, 1966
Address (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept. 20, 1966	Sunset Memorial Park	Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarnelli, Cumberland, Md.	SEP 22 1966	J. Charles Judge

VR A15ME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12112

CERTIFICATE OF DEATH

12108

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2/8/1962
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Amelia — Middle: Jane — Last: Graney
4 DATE OF DEATH: Month: September — Day: 18, — Year: 1966

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/29/1878
9 AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Midland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Seymour
14. MOTHER'S MAIDEN NAME: Laura Warren

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT: P.O.Box 599, Address Cumberland, Md
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): (1) Hypostatic pneumonia, due to degenerative Senile
DUE TO (b): (2) arteriosclerosis, generalized & Hypertension
DUE TO (c): (3) fracture Rt Hip (acc)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (4) fracture left femur (acc)
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/8/1962, 19___, to 9/18/66, 19___, that (I) (we) last saw the deceased alive on 9/17/66 19___, and that death occurred at P. M., from causes and on the date stated above.

22a. SIGNATURE: [signature] at 6:25 P.M.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 9/19/1966
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-20-66
23c NAME OF CEMETERY OR CREMATORY: Philos Cemetary
23d. LOCATION (City or Town) (County) (State): Westernport Alle. Md

24. FUNERAL DIRECTOR: W.W. Fredlock Jr
ADDRESS: Piedmont W.Va
25a. REC'D BY REGISTRAR DATE: SEP 23 1966
25b REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from state; in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12114

CERTIFICATE OF DEATH

12109

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN Hospital: 58 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 340 Davidson Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [XX]

3 NAME OF DECEASED (Type or print): First: Vernon — Middle: Cornelius — Last: Hager

4. DATE OF DEATH: Month: Sept — Day: 2 — Year: 19 66

5 SEX: male

6 COLOR OR RACE: white

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 31, 1897

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Grocer

10b KIND OF BUSINESS OR INDUSTRY: Grocery Prop.

11 BIRTHPLACE (County & State or foreign country): Cumberland, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: William Hager

14. MOTHER'S MAIDEN NAME: Edna M. Ardinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 220-30-8768

17. INFORMANT: Mrs. Anna Hager — Address: 340 Davidson St. Cumb. Md. — Pt. chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b): Generalized Abdominal Carcinomatosis — 4 mos
DUE TO (c): Carcinoma of Sigmoid Colon — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 July, 19 66, to 2 Sept, 19 66, that (I) (we) last saw the deceased alive on 2 July 19 66, and that death occurred at 4:15 PM, from causes and on the date stated above.

22a. SIGNATURE: James B. Stegmaier — M.D — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3 Sept 1966

22c PHYSICIAN'S NAME (Type): J. G. Stegmaier, M. D.

22d. ADDRESS: 122 South Centre Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/5/66

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24 FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Maryland

25a. REC'D BY REGISTRAR — DATE: SEP 8 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12115

CERTIFICATE OF DEATH

12110

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d STREET ADDRESS: 1428 DOGWOOD CT. WHITE OAKS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CLIFTON — Middle: LUTHER — Last: HANLIN
4 DATE OF DEATH: Month: SEPT. — Day: 4 — Year: 1966
5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-11-1908
9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Helper
10b KIND OF BUSINESS OR INDUSTRY: Railroad
11 BIRTHPLACE (County & State or foreign country): W.VA. -RIG
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13 FATHER'S NAME: WILLIAM R HANLIN
14. MOTHER'S MAIDEN NAME: IDA V LAMBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes — War II & Korean
16 SOCIAL SECURITY NO: 220-10-7928
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coron Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Depression Upon Recent Myocardial
DUE TO
(c) Infarction due to Hypertensive Arteriosclerotic Cardiovascular

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/3, 1966, to 9/4, 1966 that (I) (we) last saw the deceased alive on 9/4/66 19__, and that death occurred at 9:55 AM PM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/6/66
22c PHYSICIAN'S NAME (Type): DR. OVERTON D HIMMELWRIGHT
22d. ADDRESS: 133 VIRGINIA AVE. CUMBERLAND, MD

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 7, 1966
23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: SEP 12 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12111

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages (1 and 2) with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE: W. Va. — b COUNTY: Mineral
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland	c LENGTH OF STAY IN 1b: ? — c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wiley Ford
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hospital	d STREET ADDRESS — e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Madlean	Janes	Hannas	Sept.	27	19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Female	White		Jan. 27, 1909	57 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Green Ridge, Md.	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John Kifer	Estella Hutzell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT Address
no		Husband Mr. Herbert Hannas, Wiley Ford, W. Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO (b)	Coronary Sclerosis	----
DUE TO (c)		

4211
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspect on ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: September 27, 1966
Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept. 30, 1966	Sunset Memorial Park	Cumberland, Md. Allegany

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarnelli, Cumberland, Md.	OCT 3 1966	Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12117

CERTIFICATE OF DEATH

12112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 44 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND d. STREET ADDRESS: 218 CECELIA ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First ROBERT Middle M Last HOPCRAFT	4. DATE OF DEATH: Month SEPT Day 17 Year 1966
5. SEX: MALE	6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 3-27-86
9. AGE (In years last birthday): 80 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired B & O Machinist	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JACK HOPCRAFT	14. MOTHER'S MAIDEN NAME: MOLLY RHODES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 705-10-3792
17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Diffuse Cerebro Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3yrs
DUE TO: (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334X — DUE TO: (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/7/66, 19__; to 9/17/66, 19__; that (I) (saw) last saw the deceased alive on 9/17/66 19__, and that death occurred at 8:40 P.M., from causes and on the date stated above.

22a. SIGNATURE: D. Williams — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/19/66

22c. PHYSICIAN'S NAME (Type): DR. R.J.WILLIAMS

22d. ADDRESS: 122 S CENTER ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 9/21/66	23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland
24. FUNERAL DIRECTOR: Ruth E. Silcox	ADDRESS: Cumberland Maryland 21502	25a. REC'D BY REGISTRAR DATE: SEP 20 1966	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12118 Item #3 Film #G-1 10/5/76 pc

CERTIFICATE OF DEATH

12113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 217 GRAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY Middle R/ Landis Last HOYLE
4. DATE OF DEATH: Month SEPT. Day 16 Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-23-1890
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): WEST VIRGINAA
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN ~~X~~FRANK HOYLE
14. MOTHER'S MAIDEN NAME: VIRGINIA MILLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Arteriosclerosis Left Lung — Hours
DUE TO (c): Arteriosclerosis — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1633

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar, 1866 to Apr 16, 1966; that (I) (we) last saw the deceased alive on Apr 16 1966, and that death occurred at 8:55 PM, from causes and on the date stated above.

22a. SIGNATURE: Clay R. Durrett M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/17/66
22c. PHYSICIAN'S NAME (Type): DR. CLAY DURRETT
22d. ADDRESS: 236 VIRGINIA AVE.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Sept. 19, 1966
23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarmelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: SEP 22 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12119

CERTIFICATE OF DEATH

12114

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 62 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 700 LAFAYETTE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: P. — Last: IRONS

4. DATE OF DEATH: Month: SEPTEMBER — Day: 14 — Year: 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-24-1905

9. AGE (In years last birthday): 60 yrs

If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~NONE~~ Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (County & State, or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SILAS IRONS

14. MOTHER'S MAIDEN NAME: STELLA SHIELDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: 214-07-3204

17. INFORMANT: MEMORIAL HOSPITAL - Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cerebral Arrest
DUE TO (b): Arteriosclerotic Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1934, 19__ to Sept, 1966, that (I) (we) last saw the deceased alive on Sept 13 1966, and that death occurred at 4:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/14/66

22c. PHYSICIAN'S NAME (Type): DR. G. O. HIMMELWRIGHT

22d. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 17, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 22 1966

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12120 12115

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 112 SPRING STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle MUIR Last KERR

4. DATE OF DEATH: Month SEPTEMBER Day 11, Year 19 66

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 1, 1885

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DYE HOUSE

10b. KIND OF BUSINESS OR INDUSTRY: CELANESE CORP.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS KERR

14. MOTHER'S MAIDEN NAME: JEAN MUIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 214-01-3779

17. INFORMANT Address: MRS. VIRGINIA KERR, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) CORONARY SCLEROSIS

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.

Address (Street, city, town, or county) RD 9, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 13, 1966

23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK

23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: SEP 19 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12121 — 12116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing (Rural)
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing (Rural)
d. STREET ADDRESS: Knapps Meadow
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN Middle: Last: LEAKE
4. DATE OF DEATH: Month: 9/6/1966 Day: Year: 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec, 31st. 1889
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner
10b. KIND OF BUSINESS OR INDUSTRY: (COAL)
11. BIRTHPLACE (County & State, or foreign country): Clay County, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Leake
14. MOTHER'S MAIDEN NAME: Maude Winters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Thomas Powers, Lonaconing, MD. (Daughter) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Dehydration	7 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Intestinal Obstruction	21 days
DUE TO (c)	Carcinoma large bowel	14 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): ACVD & congestive failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 19 65 to Sept. 6, 19 66, that (I) (we) last saw the deceased alive on Sept. 3 19 66 and that death occurred at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: L R Miles MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9.6.66
22c. PHYSICIAN'S NAME (Type): L. R. MILES, VR, M.D.
22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/8/1966
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county) (State): Cumberland, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN
ADDRESS: Lonaconing, MD.
25a. REC'D BY REGISTRAR DATE: SEP 7 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 5-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12122

CERTIFICATE OF DEATH

12117

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RAWLINGS
d. STREET ADDRESS: R.F.# 3 BOX 179
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle ARNOLD — Last LEASE

4. DATE OF DEATH: Month SEPTEMBER — Day 26 — Year 1966

5 SEX: MALE
6 COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-7-95
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Operator
10b. KIND OF BUSINESS OR INDUSTRY: Textile Plant
11. BIRTHPLACE (County & State, or foreign country): W.VA. Fort Ashby
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GARRETT LEA E (D)
14. MOTHER'S MAIDEN NAME: ELLEN LEASE (D)

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16 SOCIAL SECURITY NO.: 214-07-6997
17 INFORMANT: Mrs. Pearl V. Lease — Address: Rawlings, Md.

PT'S CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b): Hypertensive Cardiovascular Disease — 20 yr.
DUE TO
(c): Diabetes mellitus — 15 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis and osteoarthritis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from March 31, 1952, to Sept. 26, 1966, that (I) (we) last saw the deceased alive on Sept. 26, 1966, and that death occurred at 6.20 PM, from causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-27-66
22c PHYSICIAN'S NAME (Type): James P. Hallinan M. D. DR. HALLINAN, M.D.
22d. ADDRESS: 140 BEDFORD ST. CUMBERLAND MARYLAND.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/29/66
23c. NAME OF CEMETERY OR CREMATORY: Mineral Chapel Baptist Cem.
23d. LOCATION (City or Town) (County) (State): Nr. Ft. Ashby, Mineral, W.Va.

24 FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 3 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

M 12123

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12118

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gilmore
c. LENGTH OF STAY IN (a): Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #36

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
Frostburg
I37 Water Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Samuel — Middle: M. — Last: Leptic
4. DATE OF DEATH: Month: Sept. — Day: 4 — Year: 1966

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8 DATE OF BIRTH: July I I937
9 AGE (In years last birthday): 29 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Dept.
10b KIND OF BUSINESS OR INDUSTRY: Celanese Fibres
11 BIRTHPLACE (State or foreign country): Frostburg
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Samuel Leptic
14 MOTHER'S MAIDEN NAME: Helen Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes World War 2
16. SOCIAL SECURITY NO: 2I5-34-4340
17 INFORMANT — Address: Mrs. Don Adams, I37 Water St. Frostburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Fractured neck; Ruptured Liver — Minutes
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of auto in one car accident
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 5:10 p.m. Sept. 4 1966
20d INJURY OCCURRED While at work [ ] Not While at work [X]
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.): Route # 36
20f. (City or town) (County) (State): Gilmore, Allegany, Maryland

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22. DATE SIGNED: September 4, 1966
Address (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Sept. 7 I966
23c NAME OF CEMETERY OR CREMATORY: Sunset Memorial Pk.
23d LOCATION (City or Town) (County) (State): Cumberland Allegany Md.

24 FUNERAL DIRECTOR: Hafer Funeral Home
ADDRESS: Frostburg, Md
P. H. Mattingly
25a RECD BY REGISTRAR DATE: SEP 8 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (S) 3M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and not later than 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12124 — 12119

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: LIFE
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 131 BOWERY STREET

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FROSTBURG
d STREET ADDRESS: 131 BOWERY STREET
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First HAROLD — Middle M. — Last LEWIS
4 DATE OF DEATH: Month SEPTEMBER — Day 5, — Year 19 66

5 SEX: MALE
6. COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: FEB. 5, 1917
9 AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIPPING DEPT.
10b KIND OF BUSINESS OR INDUSTRY: UNION CARBIDE
11 BIRTHPLACE (State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN E. LEWIS
14 MOTHER'S MAIDEN NAME: BESSIE MORGAN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 217-10-5002
17. INFORMANT Address: RICHARD LEWIS, ROCKVILLE, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gunshot of Head — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): (self inflicted)
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: September 5, 1966
Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: SEPT. 8, 1966
23c NAME OF CEMETERY OR CREMATORY: FB'G. MEMORIAL PARK
23d LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a RECEIVED BY REGISTRAR DATE: SEP 8 1966
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from state or in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12125

CERTIFICATE OF DEATH

12120

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 15 DAYS

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL
d. STREET ADDRESS: 41 W. COLLEGE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: CLARENCE — Middle: L. — Last: LONG

4 DATE OF DEATH: Month: SEPT. — Day: 13, — Year: 19 66

5 SEX: MALE

6. COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: OCT. 27, 1883

9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b KIND OF BUSINESS OR INDUSTRY: LADIE'S CLOTHING

11 BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY LONG

14. MOTHER'S MAIDEN NAME: ISABELLA BOUCHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 214-32-3019

17. INFORMANT Address: MRS. GRACE P. LONG, FROSTBURG, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Perforated Gastric Ulcer.
DUE TO (b): Peritonitis.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 540.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 29, 1966, to Sept 13, 1966, that (I) (we) last saw the deceased alive on Sept 12 1966, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: S. E. Enfield M.D
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Sept 15 66

22c. PHYSICIAN'S NAME (Type): S. E. ENFIELD, M. D.

22d. ADDRESS: ELLERSLIE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 16, '66

23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR., FROSTBURG, MD.
ADDRESS

25a. REC'D BY REGISTRAR DATE SEP 19 1966

25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. Any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12121

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 30 Years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 208 Union Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 208 Union Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vincent; Middle: Paul; Last: Long

4. DATE OF DEATH: Month: September; Day: 22; Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 31, 1889

9. AGE (In years last birthday): 77 yrs
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee-Celanese

10b. KIND OF BUSINESS OR INDUSTRY: Corp of America

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? Corp

13. FATHER'S NAME: Nelson Long

14. MOTHER'S MAIDEN NAME: Mary E. Cahill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 217-10-4974

17. INFORMANT: Edgar Bucy — Address: 208 Union Street, Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1201
   (b): Coronary Sclerosis — ----
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: September 22, 1966

Address (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/66

23c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: H. Lee Silcox — ADDRESS: Cumberland Maryland 21502

25a. RECD BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please type three carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12127

CERTIFICATE OF DEATH

12122

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 34 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1401 OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELWOOD Middle Ellsworth Last LONGERBEAM
4. DATE OF DEATH: Month SEPT. Day 26 Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 28, 1906
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (County & State, or foreign country): HARPERS FERRY, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GEORGE W. LONGERBEAM
14. MOTHER'S MAIDEN NAME: MARY PAINTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intes. Obstruction + Infer. F.'s — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
DUE TO (b): Gastro Intestinal Hemorrhage, massive — 4 days
DUE TO (c): Duodenal Ulcer. — 2 weeks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/12/65, 19___, to 9/26/66, 19___, that (I) (~~we~~) last saw the deceased alive on 9/26/66 19___, and that death occurred at ____ P. M., from causes and on the date stated above.

22a. SIGNATURE: M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/28/66
22c. PHYSICIAN'S NAME (Type): R. J. Williams
22d. ADDRESS: Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 29, 1966
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, ADDRESS: Cumberland, Md.
25a. RECD BY REGISTRAR DATE: OCT 3 1966
25b. REGISTRAR'S SIGNATURE: Charles Judy

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film 1,951 9/26/66 mh

12128

CERTIFICATE OF DEATH

12123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL	d. STREET ADDRESS: 125 INDEPENDENCE ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): MR. MELVIN C. LOVE (First, Middle, Last)	4. DATE OF DEATH: Month SEPT. Day 13 Year 19 66
5. SEX: MALE	6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 4/12/18
9. AGE (In years last birthday): 48 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUS DRIVER	10b. KIND OF BUSINESS OR INDUSTRY: CITY BUS LINE
11. BIRTHPLACE (County & State, or foreign country): PITTSBURGH, PA.	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: CLYDE LOVE	14. MOTHER'S MAIDEN NAME: MARGARET KING
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 220 10 6699
17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure, probably with terminal pulmonary embolus

DUE TO (b): Congenital Heart Disease, specificically infundibular stenosis, with pulmonic hypertension and cor pulmonale

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Polycythemia, presumed secondary to heart disease and hypoxemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 20, 19 59, to Sept. 12th, 19 66, that (I) (we) last saw the deceased alive on Sept. 12th, 19 66 and that death occurred at 3:39 P.M. from causes and on the date stated above.

22a. SIGNATURE: Wyand R. Doerner Jr. M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 9-14-66	
22c. PHYSICIAN'S NAME (Type): DR. WYAND DOERNER, Jr.	22d. ADDRESS: 412 N. MECHANIC ST. CUMBERLAND MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: SEPT. 15, 1966	23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK	23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.	
24. FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: SEP 16 1966	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12129

CERTIFICATE OF DEATH

12124

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 509 EASTERN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANTHONY — Middle A — Last LOWERY
4. DATE OF DEATH: Month SEPT — Day 17 — Year 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-14-1877
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee of Baking Company
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANTHONY LOWERY
14. MOTHER'S MAIDEN NAME: MARY BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 212-24-0681
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure
DUE TO (b): Coronary Arteriosclerosis
DUE TO (c):
4500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-30, 1966, to 9-17, 1966, that (I) (we) last saw the deceased alive on 9-17 1966, and that death occurred at 2:30 AM, from causes and on the date stated above.

22a. SIGNATURE: William P James — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/19/66
22c. PHYSICIAN'S NAME (Type): DR. W P JAMES
22d. ADDRESS: 441 N CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/20/66
23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
23d. LOCATION (City or Town) (County) (State): Centerville Bedford Penna

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland 21502
25a. REC'D BY REGISTRAR DATE: SEP 22 1966
25b. REGISTRAR'S SIGNATURE: Marcella Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12130

CERTIFICATE OF DEATH

13567

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 404 BEALL ST.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First AGNES — Middle — Last MCKINNEY
4. DATE OF DEATH: Month SEPT. — Day 28 — Year 19 66
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-2-1891
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — M.n
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): MARYLAND Lonaconing
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: HUGH MCMILLAN
14. MOTHER'S MAIDEN NAME: JENNIE E. SHOCKLEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 15 days
DUE TO (b): Congestion of lungs — 15 days
DUE TO (c): Renal failure due Pyelonephritis + Nephrosclerosis (Arteriosclerosis) — 15 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Thrombophlebitis L.L.E. post op + possible pulmonary
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 13, 19 66 to Sept of 66, 19___, that (I) (we) last saw the deceased alive on Sept 28 19 66, and that death occurred at 10:45 PM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/7/66
22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN
22d. ADDRESS: 59 GREENE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: October 1, 1966
23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany
24. FUNERAL DIRECTOR — ADDRESS: James F. Scarnelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 10 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12131

CERTIFICATE OF DEATH

13569

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
a. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 309 OLDTOWN RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARY; Middle L. (Lee); Last METZ

4 DATE OF DEATH: Month SEPT.; Day 30; Year 19 66

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-22-1940

9. AGE (n years last birthday) 25 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Art Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CHARLES D. CALLIS

14. MOTHER'S MAIDEN NAME: FRANCES L. DOWLING

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no (If yes g ve war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis
DUE TO (b): Fibrocaseous Chronic Tuberculosis - Bilateral
DUE TO (c): Pneumonia, Lobar
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 yr; (b) U.K.; (c) 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 19 66 to Sept. 30, 19 66; that (I) (we) last saw the deceased alive on Sept. 30 19 66, and that death occurred at 9:17 P.M., from causes and on the date stated above.

22a. SIGNATURE: Walter Kuhn M.D., Pathologist

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED: 10/1/66

22c PHYSICIAN'S NAME (Type): DR. L. L. MOULD

22d. ADDRESS: 1068 NATIONAL HIGHWAY

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 3, 1966

23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: OCT 10 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12132 Item #7 Film #351 10/6/33 DG 12125

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 40 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 211 FULTON STREET

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 211 FULTON STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH Middle B. Last MILLER

4. DATE OF DEATH: Month SEPT. Day 30 Year 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: SEPT. 9, 1891

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWNNHOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HORACE G. BUCHANAN

14. MOTHER'S MAIDEN NAME: DELILAH DeVORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: GRACE WELTMAN Address: ELLERSLIE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Thrombosis	Acute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Myocarditis & Decompensation	6 mo
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 20, 19 66 to Sept 30 19 66, that (I) (we) last saw the deceased alive on Sept 26 19 66, and that death occurred at 8 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: SEPT. 30, 1966

22c. PHYSICIAN'S NAME (Type): CLAY E. DURRETT, M.D.

22d. ADDRESS: 236 MARYLAND AVE. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: OCT. 2, 1966

23c. NAME OF CEMETERY OR CREMATORY: COOKS MILLS CEMETERY

23d. LOCATION (City, town or county) (State): ELLERSLIE, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE OCT 3 1966

25b. REGISTRAR'S SIGNATURE

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12138 — **CERTIFICATE OF DEATH** — 12126

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing d. STREET ADDRESS: 8 Furnace Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First JOSEPH — Middle H. — Last MORTON	4. DATE OF DEATH: Month 9/15/1966 Day Year 19
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 10/28/1889
9. AGE (In years last birthday): 76 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Celanese Employee	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Lonaconing, MD.	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: John Morton	14. MOTHER'S MAIDEN NAME: Elizabeth Crosser
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 217-10-5641-A.
17. INFORMANT (Address): Mrs. Jean Steele (DAUGHTER) Lonaconing, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Chronic Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO (b): arteriosclerotic Cardiovascular evolution yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS ALTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June, 1966, to Sept. 15, 1966 that (I) (~~we~~) last saw the deceased alive on Sept 15 1966, and that death occurred at 9:35 M, from causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/16/66

22c. PHYSICIAN'S NAME (Type): John B. DAVIS, M.D.

22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 9/18/1966	23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Lonaconing, MD.	
24. FUNERAL DIRECTOR ADDRESS: GEORGE EICHHORN Lonaconing, MD.		25a. REC'D BY REGISTRAR DATE: SEP 19 1966	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12134

CERTIFICATE OF DEATH

12127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Barton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: E. — Last: Moses

4. DATE OF DEATH: Month: September — Day: 20 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/12/1899

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Morton Garage

11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Moses

14. MOTHER'S MAIDEN NAME: Agnes McNeil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Felicit Moses — Address: Barton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia ("Wife") — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): ASVD — years
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Fibrosis Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 66 to Sept 20, 19 66, that (I) (we) last saw the deceased alive on Sept 20 19 66, and that death occurred at 11 p M, from causes and on the date stated above.

22a. SIGNATURE: L.R. Miles JR MD — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9.22.66

22c. PHYSICIAN'S NAME (Type): L.R. MILES JR MD

22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/23/66

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Moscow, A. Md.

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT. M

12135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12128

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN To:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Frostburg, MD. (Shaft Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CANDACE; Middle; Last MYERS

4. DATE OF DEATH: Month 9/12/1966 Day Year 19

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/3/1869
9. AGE (In years last birthday): 96 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Westernport, MD.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Nelson Meese
14. MOTHER'S MAIDEN NAME: Mary Sigler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Ada Philpot (Grandchild) Address: Shaft, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arteriosclerotic Cardiovascular disease --
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
1221
INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of Left Hip, Terminal Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH: X
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18.):
20c. TIME OF INJURY Month Day, Year: Hour a.m. 5:00 AM July 31 19 66
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home farm, factory street, office bldg., etc.): Sylvan Retreat
20f. (City or town) Cumberland, (County) Alleg. (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.
22. DATE SIGNED: Sept. 12, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/14/1966
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City or Town) Moscow, (County) MD. (State)

24. FUNERAL DIRECTOR: GEORGE EICHHORN
ADDRESS: Lonaconing, MD.
25a. RECD BY REGISTRAR DATE: SEP 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death (if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if dispatch agent within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12136 Items #14 & 17 Film #w331 10/6/66 pc

CERTIFICATE OF DEATH

12129

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland c LENGTH OF STAY IN 1b: Years	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital	d. STREET ADDRESS: 224 Glenn St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: ~~Russell~~ Samuel	Middle: Russell	Last: Nave	4 DATE OF DEATH	Month: 9	Day: 23	Year: 1966	
5 SEX: M	6 COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 8/22/00	9. AGE (In years last birthday): 66 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook	10b KIND OF BUSINESS OR INDUSTRY: Restaurant	11. BIRTHPLACE (County & State, or foreign country): Bedford Co., Penna.	12. CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Samuel Nave	14. MOTHER'S MAIDEN NAME: Anna Tewell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 214-07-3076	17 INFORMANT: Mrs. Edith Nave Carr — Address: 224 Glenn St Cumberland, Md — patient's chart	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221
(b): Arteriosclerotic Cardiovascular Disease
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 19 64 to Sept 23 19 66 that (I) (we) last saw the deceased alive on Sept 23 1966, and that death occurred at 5 A M, from causes and on the date stated above.

22a. SIGNATURE: W C Spiggle — M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22b. DATE SIGNED: Sept 25, 1966
22c. PHYSICIAN'S NAME (Type): W C Spiggle	22d. ADDRESS: 126 N. Smallwood St Cumberland, Md	

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Sept 26, 1966	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Gardens	23d. LOCATION (City or Town) (County) (State): Near Cumberland Allegany, Md.	
24 FUNERAL DIRECTOR: John J. Hafer, Jr.	ADDRESS: 230 Balto Ave Cumberland, Md	25a. REC'D BY REGISTRAR DATE: SEP 27 1966	25b. REGISTRAR'S SIGNATURE: Mary Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12137 12130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Advocate Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH — Middle: — Last: OLEWINE

4. DATE OF DEATH: Month: 9/11/1966 — Day: — Year: 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JAN, 1876

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Saleslady

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lonaconing

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Jones

14. MOTHER'S MAIDEN NAME: Elizabeth Fatkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: JEANETTE JOHNSON, Rockville, MD. (NEICE)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial ischemia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Congestive failure — weeks
DUE TO (c): ACVD — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1957 to Sept 11, 1966 that (I) (we) last saw the deceased alive on Sept 10 1966, and that death occurred at 3 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L R Miles MD — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9.12.66

22c. PHYSICIAN'S NAME (Type): L R MILES JR

22d. ADDRESS: Lonaconing Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/13/1966

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City, town or county) (State): Lonaconing, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN

ADDRESS: Lonaconing, MD.

25a. REC'D BY REGISTRAR DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 5-63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12138

CERTIFICATE OF DEATH

12131

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 16: 16 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 503 EICHNER AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ORPHA Middle Last PATTON
4. DATE OF DEATH: Month SEPT Day 17 Year 19 66
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-11-88
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): GARRETT CO, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Mahlon ~~MALLIN~~ MILLER
14. MOTHER'S MAIDEN NAME: ANNA ~~FULLER~~ Eichorn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: MEMORIAL HOSPITAL, Address CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Lesion in Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/22/66, 19__, to 9/17/66, 19__, that (I) ~~(we)~~ last saw the deceased alive on 9/17/66 19__, and that death occurred at 3:35 M, from causes and on the date stated above.

22a. SIGNATURE: R. J. Williams M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/17/66
22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
22d. ADDRESS: 122 S CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/20/66
23c. NAME OF CEMETERY OR CREMATORY: Grantsville Cem.
23d LOCATION (City or Town) (County) (State): Grantsville, Garrett, Md.

24. FUNERAL DIRECTOR: Ray Hauer Jr. ADDRESS: Grantsville, Md.
25a. REC'D BY REGISTRAR DATE: SEP 20 1966
25b. REGISTRAR'S SIGNATURE:

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12139

CERTIFICATE OF DEATH

12133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Rt #1 Bx 503
c. LENGTH OF STAY IN 1b: 4 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Rt #1 Box 503
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ada — Middle: Belle — Last: Phillips

4 DATE OF DEATH: Month: September — Day: 24 — Year: 19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Female	White		Jan 11, 1900	66 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housekeeper	At Home	Chaneysville, Penna	U.S.A.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Leonadus Pardew	Mary Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT	Address
No	161-32-9679	Leslie C. Phillips	Rt #1 Box 503 Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): metastatic carcinoma, gen'l — INTERVAL BETWEEN ONSET AND DEATH: Unk yrs
DUE TO (b): Adeno Ca of breast — 2-3 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

176X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19 66, to Sept 24, 1966, that (I) (we) last saw the deceased alive on Aug 31 1966, and that death occurred at 1:00 AM, from causes and on the date stated above.

22a. SIGNATURE: C. J. Mirkin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-24-66

22c. PHYSICIAN'S NAME (Type): Dr. A. J. MIRKIN — 22d ADDRESS: 115 So. Centre St - Cumberland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/26/66	Chaneysville Cemetery	Chaneysville Bedford Penna

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Lee Silcox Cumberland Maryland 21502	SEP 27 1966	Charles Junior

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12134

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 104 Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willis — Middle: C. — Last: Pollock

4. DATE OF DEATH: Month: Sept — Day: 17 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: August 11, 1890

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Foreman

10b. KIND OF BUSINESS OR INDUSTRY: B & O RR

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles C. Pollock

14. MOTHER'S MAIDEN NAME: Stella Iva Steele

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-385-3398

17. INFORMANT: Carroll Conrad Pollock — Address: 211 Griffith Drive, Douglasville, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Thrombosis, left — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Sclerosis, generalized — ----

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial Infarctions, old

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o'm. a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: Sept. 18, 1966

Address (Street city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 18, 1966

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State): Near Cumberland, Md.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: John J. Hafer 230 Balto. Ave. Cumberland, Md.

25a. RECD BY REGISTRAR DATE: SEP 20 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. And in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12135

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN b: 60 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 1008 Ella Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Walter — Middle: Cornelius — Last: Price

4 DATE OF DEATH: Month: Sept. — Day: 8 — Year: 1966

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: July 31, 1897

9 AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railway Postal Clerk

10b KIND OF BUSINESS OR INDUSTRY: Government

11 BIRTHPLACE (State or foreign country): Sandy Hook, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Winfield S. Price

14 MOTHER'S MAIDEN NAME: Clara M. Downs

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): War I II Korean

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. William W. Price, Address: Cumberland, Md. Son

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Coronary ~~XXXXXXXXX~~ Sclerosis — -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: Sept. 8, 1966

Address (Street, city, town, or county): Cumberland, M.D.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Sept. 10, 1966

23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24 FUNERAL DIRECTOR: James F. Scarnelli — ADDRESS: Cumberland, Md.

25a REC'D BY REGISTRAR DATE: SEP 13 1966

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (M) 6M 7/66

1 M

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12142 — 12136

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 12 Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kitzmiller
d. STREET ADDRESS: 3rd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LeRoy — Middle: Adolphus — Last: Propst

4. DATE OF DEATH: Month: Sept. — Day: 29 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.10,1902

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Track Foreman

10b. KIND OF BUSINESS OR INDUSTRY: W.Md. Railroad

11. BIRTHPLACE (State or foreign country): Moore, Tucker Co. W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred Floyd Propst

14. MOTHER'S MAIDEN NAME: Mary Ellen Huffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-10-6050-

17. INFORMANT — Address: Brooks E. Evans, Kitzmiller, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO (b): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Ruptured abdominal arteriosclerotic aneurysm — Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a: Coronary Sclerosis, Marked

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: September 29, 1966

Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.2,1966

22c. NAME OF CEMETERY OR CREMATORY: Garrett Co. Memorial Gardens- Oakland, Md.

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR: Amy Mildred Sharpless — ADDRESS: Blaine, W.Va. P.O. Kitzmiller, Md.

24a. REC'D BY REGISTRAR DATE: OCT 3 1966

24b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12143 — 12137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG c. LENGTH OF STAY IN 1b: 14 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LONACONING
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL	d. STREET ADDRESS: 102 JACKSON STREET e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET	Middle E.	Last RAVENSCROFT	4. DATE OF DEATH: Month SEPTEMBER	Day 14,	Year 1966			
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: FEB. 1, 1915	9. AGE (In years last birthday): 51 yrs	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITRESS	10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT	11. BIRTHPLACE (County State, or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FRANK W. RALEY		14. MOTHER'S MAIDEN NAME: CLARA A. MILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 220-16-6749	17. INFORMANT Address: HILLARY RAVENSCROFT, LONACONING, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Chronic myocardial failure

DUE TO (b): Hypertensive heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1966, to Sept. 14, 1966 that (I) (we) last saw the deceased alive on Sept. 17 1966, and that death occurred at 10:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: G. Paige Strong	M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 9/15/66	
22c. PHYSICIAN'S NAME (Type): A. P. STRONG, M. D.	22d. ADDRESS: E. MAIN ST., FROSTBURG, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: 9-17-66	23c. NAME OF CEMETERY OR CREMATORY: FROSTB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR.,	ADDRESS: FROSTBURG, MD.	25a. REC'D BY REGISTRAR DATE: SEP 19 1966	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12144

CERTIFICATE OF DEATH

12138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d STREET ADDRESS: 827 Mt. Royal Avenue
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Harry — Middle: Francis — Last: Reinhart

4. DATE OF DEATH: Month: 9 — Day: 20 — Year: 1966

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/10/77

9 AGE (In years last birthday): 89 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Supervisor retired

10b KIND OF BUSINESS OR INDUSTRY: Kelly Tire Plant

11 BIRTHPLACE (County & State, or foreign country): Cumberland Allegany Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Francis Reinhart

14. MOTHER'S MAIDEN NAME: Mary A. Downey

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16 SOCIAL SECURITY NO.: 215-12-7228-A

17 INFORMANT: patient's chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b): Myocardial infarction subacute — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatic hypertrophy

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19 67, to 9/20, 19 66, that (I) (we) last saw the deceased alive on 9/14 19 66, and that death occurred at _____ M, from causes and on the date stated above.

22a SIGNATURE: S. G. Weisman M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/22/66

22c. PHYSICIAN'S NAME (Type): S. G. Weisman, M.D.

22d. ADDRESS: 59 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 9/22/66

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

25a REC'D BY REGISTRAR DATE: SEP 20 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 318 Bedford St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

91

3. NAME OF DECEASED (Type or print): First: Harry; Middle: N.; Last: Rice
4. DATE OF DEATH: Month: 9; Day: 27; Year: 19 66
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 18, 1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Union Laundry Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John N. Rice
14. MOTHER'S MAIDEN NAME: Olive Francis North
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 214-05-7712A
17. INFORMANT: Mrs. Hazel K. Rice — Address: 318 Bedford St Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis
DUE TO
(c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o'm. a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.
22. DATE SIGNED: September 27, 1966

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/30/66
23c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR — ADDRESS: Dale L. Merritt Cumberland Maryland 21502
25a. REC'D BY REGISTRAR DATE: SEP 29 1966
25b. REGISTRAR'S SIGNATURE: Marley Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12146 — Reg. Dist. No. 12140

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 4 Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brice Hollow Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 4 Cumberland, 21-1
d. STREET ADDRESS: Brice Hollow Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: Wade — Last: Rice

4. DATE OF DEATH: Month: Sept. — Day: 5, — Year: 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: June 30, 1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm owner
11. BIRTHPLACE (State or foreign country): Twiggtown, Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Millard E. Rice
14. MOTHER'S MAIDEN NAME: Sarah V. Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-34-1434
17. INFORMANT: Mrs. Ruth Rice — Address: Rt. # 4 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

(b): Advanced Coronary Insufficiency

DUE TO

(c): Generalized atherosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Stokes-Adams Syndrome

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7.3. 19 59 to 9.5 19 66, that I last saw the deceased alive on 8.31.66 19, and that death occurred at 8:00P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. Iames M.D.
ADDRESS (Street, city or town, state): 441 N. Centre St
DATE SIGNED: 9.6.66

PHYSICIAN'S NAME (Type): William P. Iames, M.D. — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/8/66
22c. NAME OF CEMETERY OR CREMATORY: Mount Pleasant Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Cumberland, Allegany Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 9 1966
24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12147 12141

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/13/1966
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Rt. #1, Valley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sterling Middle: Ward Last: Ryan
4. DATE OF DEATH: Month: September Day: 12, Year: 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/24/1885
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Tire Worker at Kelly Tire Plant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): West Virginia, St. George
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Daniel Webster Ryan
14. MOTHER'S MAIDEN NAME: Tabitha Hester Parsons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: 214-07-1145
17. INFORMANT: Mrs. Delta Ryan, Address: RD. #1 Valley Rd. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) (1) Hyperplasia, Chr. degenerative
DUE TO (2) Arterio Sclerosis & Hypotension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) (3) Parkinsons Disease, Severe.
(c) (4) Bilateral Cataracts
(5) Incontinence of bowels & Bladder.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/13/66, 19___, to 9/12/66, 19___, that (I) (we) last saw the deceased alive on 9/10/66 19___, and that death occurred at 4:00 A.M. on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 9/12/1966
22c. PHYSICIAN'S NAME (Type): Lee B. Mathews, M. D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 9/15/66
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: SEP 16 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (II) 2■■ 1/66

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12148 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12142

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 196 W. MECHANIC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: K. — Last: SATHOFF

4. DATE OF DEATH: Month: SEPT. — Day: 30, — Year: 19 66

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 13, 1890

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CONRAD BRODE

14. MOTHER'S MAIDEN NAME: RACHEL KIRKWOOD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-28-7676

17. INFORMANT: MRS. JOSEPH LEWIS, FROSTBURG, MD. Address 39 W. FIRST ST.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis — --
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22. DATE SIGNED

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D. Address (Street, city, town, or county) RD 1, CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 3, 1966
23c. NAME OF CEMETERY OR CREMATORY: FB'G. MEMORIAL PARK
23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: OCT 5 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

1 Supplies

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12149

CERTIFICATE OF DEATH

12143

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 56 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 429 Arch Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Schultz

4. DATE OF DEATH: Month: September — Day: 17 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-4-10

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Cumberland Allegany, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Whitman (D)

14. MOTHER'S MAIDEN NAME: Kathern (Smith) Whitman (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: Patients Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinomatosis - OVARY
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Abscess of Femoral Canal

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-20, 19 66, to 9-17, 19 66, that (I) (we) last saw the deceased alive on 9-17 19 66, and that death occurred at 11 A M, from causes and on the date stated above.

22a SIGNATURE: L. Glick M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-20-66

22c. PHYSICIAN'S NAME (Type): L. Michael Glick

22d. ADDRESS: 120 N. Smallwood

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 19, 1966

23c NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Briggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12150 12144

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LONACONING
c. LENGTH OF STAY IN 1b: 27 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KYLE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle W. Last SCHURG

4. DATE OF DEATH: Month SEPT. Day 15, Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 1, 1888

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER

10b. KIND OF BUSINESS OR INDUSTRY: COAL

11. BIRTHPLACE (County & State, or foreign country): DEAL, PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CARL SCHURG

14. MOTHER'S MAIDEN NAME: JULIA DELBROOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-6806

17. INFORMANT: MR. HARRY SCHURG, 1231 NATIONAL HGHY. Address LAVALE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic CVDisease & congestive failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 1964, to Sept. 15, 1966, that (I) (we) last saw the deceased alive on Sept. 14 1966, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9.17.66

22c. PHYSICIAN'S NAME (Type): LESLIE R. MILES, M.D.

22d. ADDRESS: STATE ROAD, LONACONING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 18, 1966

23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK

23d. LOCATION (City, town or county) (State): FROSTBURG, MARYLAND

24. FUNERAL DIRECTOR: Marilou M. Sowers MARILOU M. SOWERS ADDRESS: HAFER FUNERAL HOME 60 W. MAIN ST. FROSTBURG

25a. REC'D BY REGISTRAR DATE: SEP 22 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12157

CERTIFICATE OF DEATH

12145

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRHOPE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLADYS — Middle C. — Last SHAFFER
4. DATE OF DEATH: Month SEPTEMBER — Day 13 — Year 19 66
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-2-93
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): HYNDMAN, PA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN SHOUP
14. MOTHER'S MAIDEN NAME: LAURA CLITES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 78-12-4741
17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident & Acute Hemiplegia
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
331X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Insufficiency; Osteoarthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/21 19 65 to 7/13 19 66, that (I) (we) last saw the deceased alive on 9/12 19 66, and that death occurred at 5:45 A.M. P.M. from causes and on the date stated above.

22a. SIGNATURE: Leo H. Ley Jr M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/15/66
22c. PHYSICIAN'S NAME (Type): DR. LEO LEY
22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 16, 1966
23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
23d. LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.
24. FUNERAL DIRECTOR: Harvey H. Zeigler, ADDRESS: Hyndman, Pa.
25a. REC'D BY REGISTRAR DATE: SEP 19 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12152

CERTIFICATE OF DEATH

12146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CORRIGANVILLE,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: MRS. SUSAN	Middle: M	Last: SHAFFER	4 DATE OF DEATH	Month: September	Day: 15,	Year: 1966	
5 SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 8/17/82	9. AGE (In years last birthday): 84 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country): PENNSYLVANIA,	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME: Tobias Miller	14. MOTHER'S MAIDEN NAME: Lydia Phillippi							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.						

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Generalized Arteriosclerosis

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 4500

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June, 1966, to 9-15, 1966 that (I) (we) last saw the deceased alive on 9-15 1966, and that death occurred at 10.35 AM from the causes and on the date stated above

22a. SIGNATURE: William P James M.D.	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED: 9/15/66	
22c. PHYSICIAN'S NAME (Type): DR. WILLIAM JAMES	22d. ADDRESS: 441 N CENTRE ST. CUMBERLAND, MD.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: Sept. 18, 1966	23c NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery	23d LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.	
24 FUNERAL DIRECTOR: Harvey H. Zeigler	ADDRESS: Hyndman, Pa.	25a. REC'D BY REGISTRAR DATE: SEP 19 1966	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12153 — 12147

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 31 HAWTHORNE DRIVE BRADDOCK ESTATES
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle HASKELL — Last SHIELDS
4. DATE OF DEATH: Month SEPTEMBER — Day 28, — Year 19 66

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 25, 1900
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JUNIOR EXECUTIVE
10b. KIND OF BUSINESS OR INDUSTRY: JOHNS-MANVILLE
11. BIRTHPLACE (County & State, or foreign country): KENTUCKY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MILTON SHIELDS
14. MOTHER'S MAIDEN NAME: MARTHA MC KENNEY MD.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 086-07-1189
17. INFORMANT: DRIVE, BRADDOCK ESTATES, FROSTBG Address MRS. WILLIAM H. SHIELDS, 31 HAWTHORNE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PRIMARY HEPATOMA (LIVER) — INTERVAL BETWEEN ONSET AND DEATH: 6 mos 2 wks
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966, to 9/28, 19 66, that (I) (we) last saw the deceased alive on 9/28 1966, and that death occurred at 4:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Martin M. Rothstein M.D. — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/29/66
22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN, M.D.
22d. ADDRESS: 48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 1, 1966
23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK
23d. LOCATION (City, town or county) (State): FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR: MARILOU M. SOWERS HAFER FUNERAL HOME — ADDRESS: 50 W. MAIN ST., FROSTBURG
Marilou M. Sowers
25a. REC'D BY REGISTRAR DATE: OCT 3 1966
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12154

CERTIFICATE OF DEATH

12148

M

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

c. LENGTH OF STAY IN 1b: 32DAYS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLDTOWN

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

d. STREET ADDRESS: ROUTE 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MRS. ELIZABETH Middle P. Lost SLIDER

4 DATE OF DEATH: Month SEPT Day 16 Year 19 66

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/11/98

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS RICHARDSON

14 MOTHER'S MAIDEN NAME: ~~MARY HUFF~~ IDA HUFF

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17 INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Obstructive jaundice due to — INTERVAL BETWEEN ONSET AND DEATH: 3-6 mos.
DUE TO (b): +/- Carcinoma, bile ducts — ? 6-12 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1966, to Sept 15, 1966 that (I) (we) last saw the deceased alive on Sept 15 1966, and that death occurred at 9.15 AM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/18/66

22c. PHYSICIAN'S NAME (Type): DR. A.J.MIRKIN/

22d. ADDRESS: 115 S CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 19, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, 230 Balto Ave., Cumberland, Md

25a. REC'D BY REGISTRAR DATE: SEP 20 1966

25b. REGISTRAR'S SIGNATURE: [signature] Registrar Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12155

CERTIFICATE OF DEATH

12149

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cresaptown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: L. — Last: Snyder

4. DATE OF DEATH: Month: 9 — Day: 21 — Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/29/96

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (County & State, or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Snyder

14. MOTHER'S MAIDEN NAME: Laura (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Miles Snyder, patient's chart, Route 6, Box 114, Cumberland Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hours ?
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Acute Bronchitis — 1 week
DUE TO
(c): Pulmonary Emphysema and Cor Pulmonale. — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 20th, 1966, to Sept 21st 1966, that (I) (we) last saw the deceased alive on Sept. 21st 1966, and that death occurred at 2:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr.
M.D ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 22, 1966

22c. PHYSICIAN'S NAME (Type): Wyand F. Doerner, Jr., M.D.

22d. ADDRESS: 414 N. Mechanic Street, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 24, 1966

23c. NAME OF CEMETERY OR CREMATORY: Levels Cemetery

23d. LOCATION (City or Town) (County) (State): Levels Hampshire W.Va.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer 230 Balto Ave., Cumberland, Md

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12156 — 12150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (please) remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 3 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MIDLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: WILLIAM	Middle: H.	Last: SPIKER	4 DATE OF DEATH	Month: SEPT.	Day: 28,	Year: 1966				
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 11-11-1913	9. AGE (In years last birthday): 52 yrs	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): MT. SAVAGE, MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13. FATHER'S NAME: EDGAR SPIKER	14. MOTHER'S MAIDEN NAME: MEME MC DONALD										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: MEMORAAL HOSPITAL, CUMBERLAND, MD.									

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Hypertension
DUE TO (c): cerebral arteriosclerosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/25/66, 19__, to 9/27/66, 19__, that (I) (we) last saw the deceased alive on 9/27/1966, and that death occurred at 5:50 ☒ A.M. ☐ P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 9/28/66

22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN — 22d. ADDRESS: 59 GREENE ST.,

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 10/1/66	23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park	23d. LOCATION (City or Town): Frostburg	(County): A.	(State): Md	
24. FUNERAL DIRECTOR: George Eichhorn	ADDRESS: Lonaconing, Md.	25a. RECD BY REGISTRAR DATE: OCT 3 1966	25b. REGISTRAR'S SIGNATURE: [signature]			

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill out Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and file data event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12151

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): rural Westernport
c. LENGTH OF STAY IN To: Min-s
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): State Rt. 135

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 235 Greene
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Terrell
4 DATE OF DEATH: Month: Sept — Day: 2 — Year: 1966

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: April 6, 1915
9 AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab. Technician
10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill
11 BIRTHPLACE (State or foreign country): W.Va.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Everett Springer
14 MOTHER'S MAIDEN NAME: Carrie Harr

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 214-34-1363
17 INFORMANT: Michael Stakem — Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ruptured Heart — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Crushed Chest — H
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5164
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Passenger in a two car accident
20c. TIME OF INJURY Month, Day, Year: Hour 10:45 pm Sept. 2 1966
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm factory, street office bldg., etc.): Street
20f (City or town) Near McCoole, (County) Allegany, (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE, EXAMINER'S NAME (Type): Benedict Skitarelic M.D. — Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: Sept. 3, 1966
Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/6/66
23c. NAME OF CEMETERY OR CREMATORY: St. Peters
23d LOCATION (City or Town) (County) (State): Westernport Md.

24. FUNERAL DIRECTOR: E.S. Boal — ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: SEP 5 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5-66) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12158 12152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: MARYLAND 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital - Frostburg, Md

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 247 Lower Consol Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel Middle: Israel Last: Thomas, Sr.

4. DATE OF DEATH: Month: September Day: 9 Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 27, 1902

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp

11. BIRTHPLACE (County & State, or foreign country): Allegany Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: John B. Thomas

14. MOTHER'S MAIDEN NAME: Ada ~~Walbert~~ Thomas Walbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Georga A. Thomas, Route 2, Box 293, Frostburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Possible Peptic Ulcer — ? ?
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension & Coronary Artery Heart Disease Aortic Insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/6, 1966 to 9/9, 1966 that (I) (we) last saw the deceased alive on 9/9, 1966, and that death occurred at 9:11 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Martin Rothstein M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/10/66

22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D.

22d. ADDRESS: 48 BROADWAY - FROSTBURG MD 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 12, 1966

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION (City, town or county) (State): Frostburg, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer
John J. Hafer

ADDRESS: 230 Balto Ave. Cumberland, Md

25a. REC'D BY REGISTRAR DATE: SEP 14 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film 6.3 2/12/66 pc

12159

CERTIFICATE OF DEATH

12153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: GARRETT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 4 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BLOOMINGTON
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS: BOX 36 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
LIDIA	L	TICHNELL	SEPTEMBER	8	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
FEMALE	WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	3-2-1893	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY BARNARD	RACHEL WARNICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		MEMORIAL HOSPITAL, CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Arterio Sclerotic Cardiovas. Dis. — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c): Generalized Arterio Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

4221

seen 12:30 P.M.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12:30, 19 66 to 9-8-, 19 66, that (I) ~~(we)~~ last saw the deceased alive on 9-8- 19 66 and that death occurred at 12:55 PM from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
W. F. Williams M.D.	☒	☐	☐	9-9-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. W. F. WILLIAMS	122 S. CENTRE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/11/66	Philos Cemetery	Westernport Ft Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE: SEP 14 1966	25b. REGISTRAR'S SIGNATURE
[illegible]	[illegible]		J. Charles Judge

VR A15 (4)
20 M 1/66

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12160

CERTIFICATE OF DEATH

12155

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 27DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
d. STREET ADDRESS: 219 PACA ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: A. August — Last: WEBER
4. DATE OF DEATH: Month: SEPT — Day: 26, — Year: 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-21-1917
9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy equip. opr.
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: GEORGE W. WEBER
14. MOTHER'S MAIDEN NAME: EFFIE FROST
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No, (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-07-0636
17. INFORMANT — Address: MEMORIAL ~~AXE~~ HOSPITAL, CUMB. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF GALL BLADDER with
DUE TO (b): Metastasis to the Liver
DUE TO (c): TERMINAL Cachexia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 1 year plus / 1 year?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 21, 1966, to Sep 26, 1966 that (I) (we) last saw the deceased alive on Sep 26 1966, and that death occurred at 7:35 PM, from causes and on the date stated above.

22a. SIGNATURE: Wayne M Faw Jr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sep 27, 1966
22c. PHYSICIAN'S NAME (Type): DR. WYLIE FAW
22d. ADDRESS: 122 S. CENTRE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/29/66
23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 3 1966
25b. REGISTRAR'S SIGNATURE: [illegible], Co Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12161

CERTIFICATE OF DEATH

12156

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: LIFE
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 308 ARCH STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ERNEST — Middle SYLVESTER — Last WEISENMILLER

4. **DATE OF DEATH**: Month SEPTEMBER — Day 9 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-27-1896

9. AGE (In years last birthday): 70 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JACOB WEISENMILLER

14. MOTHER'S MAIDEN NAME: ELEANOR (YUPA) WEISENMILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
    (If yes give war or dates of service): War I

16. SOCIAL SECURITY NO.

17. INFORMANT: PTS. CHART — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c).)
    PART I DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Anaemia — INTERVAL BETWEEN ONSET AND DEATH: Years
    DUE TO (b): Myocarditis & Decompensation — 1 yr.
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Arteriosclerosis — 5 yrs.

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1965, to Sept 4, 1966 that (I) (we) last saw the deceased alive on Sept 4 1966 and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/11/66

22c. PHYSICIAN'S NAME (Type): CLAYE E. DURRETT, M.D.

22d. ADDRESS: 236 Virginia Ave. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 12, 1966

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 14 1966

25b. REGISTRAR'S SIGNATURE: Charles Jones

1 M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12157

1 PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE: MARYLAND — b. COUNTY: ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — c LENGTH OF STAY IN 1b: LIFE	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND 21-1
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 524 CUMBERLAND STREET	d STREET ADDRESS: 524 CUMBERLAND STREET — e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First / Middle / Last	4 DATE OF DEATH Month / Day / Year
SAMUEL G. WEISKETTEL	SEPT. 29 19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
MALE	WHITE		JULY 13,1891	75 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
SALESMAN	FOOD	MARYLAND	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
GEORGE W. WEISKETTEL	LUCY TRANARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT	Address
NO	214 05 5811	MRS. FRANCES THOMAS	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	CORONARY SCLEROSIS	----
DUE TO		
(c)		

4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21 **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: September 29, 1966

Address (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	OCT. 2,1966	GREENMOUNT CEMETERY	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	OCT 3 1966	Harley Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12163 12158

1 PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN (b): 20 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if inst tution Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT 2 HAZEN RD. BOX 786
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EMANUEL Middle: P Last: WELSH
4. DATE OF DEATH: Month: SEPT Day: 20 Year: 19 66
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-1-1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman Helper
10b. KIND OF BUSINESS OR INDUSTRY: B&O RR Forge
11. BIRTHPLACE (County & State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: JOHN WELSH
14. MOTHER'S MAIDEN NAME: ANNABELLE *WELSH (UNKNOWN)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 220-10-2501A
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Pneumonia, R. L. lob., acute, — 3 week
DUE TO (c): Hypertension & A.S. Cardiovascular disease — 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gen. arteriosclerosis Diabetes mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Sept., 19 66 to 20 Sept., 19 66; that (I) (we) last saw the deceased alive on 20 Sept. 19 66, and that death occurred at 12:55 PM, from causes and on the date stated above

22a. SIGNATURE: W. Alfred Van Ormer, M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 20 Sept. 66
22c. PHYSICIAN'S NAME (Type): DR. W A VAN ORMER
22d. ADDRESS: 122 S CENTER ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 23, 1966
23c. NAME OF CEMETERY OR CREMATORY: Bald Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Near Cumberland Allegany Md
24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, 230 Balto Ave. Cumberland, Md
25a. REC'D BY REGISTRAR DATE: SEP 26 1966
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12164

CERTIFICATE OF DEATH

12159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT. 2, WILLIAMS RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle B. Last WHETZEL
4. DATE OF DEATH: Month SEPT. Day 21. Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-17-1902
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Utility Man
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (County & State, or foreign country): MARYLAND Moorefield, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: BEN WHETZEL (Benjamin)
14. MOTHER'S MAIDEN NAME: BARBARA PARKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Carcinoma Left Lung — 1 mon
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last. 163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1966 to Sept. 21, 1966 that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at 8:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/22/66
22c. PHYSICIAN'S NAME (Type): DR. CLAY DURRETT
22d. ADDRESS: 236 VIRGINIA AVE.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 25, 1966
23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: SEP 28 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Guise

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12160

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: D O A
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Flintstone
   d. STREET ADDRESS: Route 1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: Perrin — Last: Willison

4. DATE OF DEATH: Month: September — Day: 18 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 8, 1916

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman & Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Norval Willison

14. MOTHER'S MAIDEN NAME: Judy Perrin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Paul Bucholtz, 221 Nat'l Hwy, La Vale, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Thrombosis, Right — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Sclerosis — ----
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county): Cumberland, Maryland

22. DATE SIGNED: September 18, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept 21, 1966
23c. NAME OF CEMETERY OR CREMATORY: IOOF Cemetery
23d. LOCATION (City or Town) (County) (State): Flintstone Allegany Md

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, 230 Balto Ave. Cumberland, Md

25a. REC'D BY REGISTRAR — DATE: SEP 20 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12166 12161

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 208 Spring Street

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Gormania, W. Va.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First NELLIE — Middle MAE — Last WILSON

4 DATE OF DEATH: Month September — Day 26, — Year 19 66

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Sept. 16, 1887

9 AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: Own home

11 BIRTHPLACE (State or foreign country): Edinburg, Virginia

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Marcus P. Jack

14 MOTHER'S MAIDEN NAME: Virginia Clem

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT: (Son) Address: Richard Wilson, Spring Hill, W.Va.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Sclerosis — ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: September 26, 1966

Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: 9/30/66

23c NAME OF CEMETERY OR CREMATORY: Beinhauer Crematory

23d LOCATION (City or Town) (County) (State): Pittsburgh, Alleg. Pa.

24. FUNERAL DIRECTOR: O. Durst — ADDRESS: John O. Durst
Leighton-Durst Funeral Home, Oakland, Md.

25a REC'D BY REGISTRAR DATE: SEP 30 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12167

CERTIFICATE OF DEATH

12162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 2 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: GARRETT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SWANTON
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First PERRY — Middle WILLIAM — Last WILT

4. DATE OF DEATH: Month SEPT. — Day 14 — Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-5-1893

9. AGE (In years last birthday): 72 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): SWANTON, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CEPHAS WILT

14. MOTHER'S MAIDEN NAME: ELIZA V. DARR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 214-16-2257

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Massive Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
   DUE TO (b): Perforated Marginal ulcer, Stomach — 2 d
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Large abdominal Aortic Aneurysm, ASHD

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-12, 1966, to 9-14, 1966, that (I) (we) last saw the deceased alive on 9-14 1966, and that death occurred at 12:00 PM, from causes and on the date stated above.

22a. SIGNATURE: William P James — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/15/66

22c. PHYSICIAN'S NAME (Type): DR. W. P. JAMES

22d. ADDRESS: 441 N. CENTRE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/17/66

23c. NAME OF CEMETERY OR CREMATORY: Gaster

23d. LOCATION (City or Town) (County) (State): Garrett County Md.

24. FUNERAL DIRECTOR: E. L. Broadwater — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12168 — 12163

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 360 Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph, Middle: Edward, Last: Wolford
4. DATE OF DEATH: Month: Sept. Day: 3 Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/1/05
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months 9 Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Technician
10b. KIND OF BUSINESS OR INDUSTRY: Amusement Co.
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: Edward Wolford
14. MOTHER'S MAIDEN NAME: Mary (Wolford) Wolford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-6227
17. INFORMANT: Mrs. Irene O. Wolford Address Cumb. Md. 360 Frederick St. Patient's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion with shock — INTERVAL BETWEEN ONSET AND DEATH: 4½ days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary arteriosclerosis — years (?)
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema; arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 31, 1966, to Sept. 3, 1966, that (I) (we) last saw the deceased alive on Sept. 3rd 1966, and that death occurred at 10:50 a.m., from couses and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 5, 1966
22c. PHYSICIAN'S NAME (Type): Wyand F. Doerner, Jr., M.D. Dr. Doerner
22d. ADDRESS: ~~826 Windsor Road~~ 414 N. Mechanic St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/6/66
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 8 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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